IOWACARE: ACT II, FIN

IowaCare Overview

- 1115 Demonstration Waiver to:
  - Retain federal revenue
  - Replace older safety net programs with statewide program.
  - Expand access to health care
  - Medicaid reform initiatives
- 5-year approval – 7/1/2005 to 6/30/2010
- CMS approval / budget neutrality

IowaCare Overview

- Eligibles = Adults age 19-64 below 200% FPL
  - Small group of 200%-300% pregnant women,
  - former state papers grandfathered.
- Services = Inpatient, outpatient hospital, physician, limited dental and transportation.
- Providers = UIHC and Broadlawns ONLY (because their GF/County dollars funded the program).
- Sliding scale premiums – originally 10% FPL up, changed to 100% FPL up.

IowaCare Overview

- Financing
- FY 2011 total program expenditures = $149 million (state and federal match combined)
  - UIHC hospital = $76.3M, UIHC physicians = $14M
  - Broadlawns appropriation = $51M
  - FQHCs = $6M
  - Non-participating hospitals = $2M

- Pays providers for health care services for covered members.
- Funding sources for the $149M in payments:
  - $106 million Federal
  - $44 million State Share (non-General Fund)
    - $38M Broadlawns Polk County property tax funds
    - $6M “Certified Public Expenditures” from UIHC
    - $600K Hospital Provider Tax

Program successes

- Expanded access to and coverage for health care:
  - Originally planned to cover 14,000. Current enrollment over 37,000
  - 82,285 Iowans served from 7/1/05 to 12/31/09 (unduplicated count)
  - Has become a key strategy for covering uninsured adults, even with program limitations
- Help for uncompensated care:
  - The program will have provided over $500M in acute health care services over 5 years. Without the program, members only have access to uncompensated emergency room care.

Program successes

- Continuity of Care:
  - 45% have been continuously enrolled for 12 months or more
  - 25% of members reported never having had health insurance in the past, 2/3 were uninsured for 2 years or more prior to enrollment (IowaCare evaluation report)
- Access to Care for high need population:
  - 80% have chronic disease diagnosis (Coronary Artery Disease, Hypertension, Diabetes, Hyperlipidemia, Chronic Obstructive Pulmonary Disease, Thyroid Disorders, Chronic Pain).
  - 25% of enrollees served by Broadlawns diabetic.
  - The population self-reports significantly lower health status than the regular adult Medicaid population

Program limitations

- Lack of local access to care:
  - Great distances to travel in many areas of the state.
- Lack of comprehensive coverage (no drugs, DME, home health, etc)
- Likely paying higher costs for more expensive services due to lack of access to local care, especially primary care
- Burden to providers due to lack of reimbursement for key services, especially physician services at UIHC.

Extension

- 1115 expires June 30, 2010
- 2009 bill language directs DHS to seek renewal/extension for program with no major changes
- August 2009 began negotiation process with CMS
- Achieved early agreement on key points (program would continue under basically same terms)
- Negotiation over 8 months has been over relatively minor technical details

Extension Terms

- 3 year term (July 1, 2010 to June 30, 2013)
- Same provider network
- Same benefit package
- Same eligibility standards
- Eliminate prohibition on provider taxes
- Move SED waiver to 1915(c)
- Remove cost limit for public providers
- Budget neutrality same terms, 7% annual increase

Extension & Affordable Care Act

- Changes due to Affordable Care Act:
  - Added 6 months to terms (3 1/2 Year extension to 1/1/2014)
  - Transition to Medicaid expansion under Affordable Care Act 1/1/2014
  - IowaCare will end and transition to new Medicaid group with comprehensive provider network and benefit package

Expansion – Part 1

- Fall 2009 – Health Coverage Commission
- Focus on expanding coverage for adults, especially improving local access for IowaCare
- IME presented 5 options for expanding the provider network – cost from $0 to $40M
- Estimate 100,000 Iowans eligible but not enrolled
- The better the program, the more the demand…have to consider ability of the state to fund if demand increases dramatically.

Expansion – Part 2 (SF 2356)

- SF 2356 - Regional primary care network
  - Phase-in local access to primary care.
    - Specifically, Federally Qualified Health Centers (FQHC)
    - Consider budget constraints & MOE
    - Start with most underserved areas of the state
    - Consult with MAPAC, MAPAC must approve plan
  - Medical Home
    - Adopt rules
    - Collaborate with Medical Home Advisory Council
  - Payment method for “nonparticipating” hospitals

Expansion – Part 2 (SF 2356)

- SF 2356 – Financing, etc:
  - Financing:
    - Increased costs financed through Certified Public Expenditures at UIHC
    - No GF cost
    - $14M physician reimbursement at UIHC, $6M for regional primary care services, and $2M for other hospitals
  - Report on transportation costs due 12/15/10
  - Requirement for providers to work together to optimize efficiency and effectiveness in patient care delivery.

Expansion Plan Development

- March/April 2010 developed draft plan
- Collaboration with stakeholders on draft (key dates):
  - March 25 – IDPH
  - April 6 – INEPCA (FQHCs)
  - April 8 – NASHP technical assistance site visit
  - April 16 – Medical Home Advisory Council
  - April 22 – UIHC
  - April 30 – Prevention and Chronic Disease Council
  - May 5 – Broadlawns
  - May 13 - MAPAC
- Revised Terms and Conditions submitted to CMS April 22, 2010

Expansion Plan – for review

- Timeline
  - June 2010 – file administrative rules
  - Effective July 1, 2010:
    - CPE financing
    - Payment to UIHC physicians up to $14M cap
  - Effective October 1, 2010:
    - Add 1 – 2 FQHCs (Sioux City & Council Bluffs – furthest from UIHC)
    - Medical Home model in FQHCs, UIHC and Broadlawns
    - Non-participating hospitals program up to $2M
  - January 1, 2010 - evaluate population growth, expenditures to determine further expansion.

Expansion Plan – for review

- Goals of expansion:
  - Increase local access to primary care
  - Adopt medical home model to concentrate care in primary care setting
  - Increase usage of Health Information Technology to improve coordination and efficiency of care
  - Adopt referral protocols
  - Peer consultation between primary care setting and UIHC specialists to avoid need for trips to UIHC
  - Measurement of quality, outcomes and utilization impacts

Expansion Plan – for review

- Iowa's Medical Home definition:
  - "Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in section 135.158.

Expansion Plan – for review

- Detailed review of proposed roll-out and Medical Home Model

- See “IowaCare Medical Home Model” document
- See FQHC map

Expansion Plan – for review

- Drafted a plan that meets the statutory requirements, but also:
  - Is consistent with other state's models (should be approvable by CMS)
  - Is a model that can be 'exported' to the regular Medicaid program
  - Deliberate, slow phase-in to manage budget impacts
  - NOTE: We will not likely be able to apply a waiting list due to MOE. Funding has narrow margin for error.
- The plan must be approved by MAPAC in order for implementation or further work to occur
- We respectfully request your consideration and approval of the plan

Health Care Reform

- End of eligibility ‘categories’ that excluded most adults from Medicaid
- Mandatory Medicaid expansion to 133% of the Federal Poverty Level – January 1, 2014
- Includes all non-disabled, childless adults
- 80,000 to 100,000 new enrollees
- Enhanced federal funding
- New income standard (modified adjusted gross income)

Health Care Reform

- Benchmark plan
- Medicare rates for primary care services

- "Exchange" – forum to purchase individual insurance
  - Premium assistance subsidies
  - Seamless eligibility between public and private programs
  - Need to re-engineer eligibility processing in connection with the Exchange